examination to be one of disseminated sclerosis. A man of fifty-four years had bulbar symptoms, with muscular atrophy and spastic paresis. Disturbance of deglutition and speech, atrophy of the tongue and lips, bilateral facial paralysis, atrophy of the small muscles of the hands, spastic paresis of the lower extremities, indicated involvement of the motor tracts. The classical symptoms of multiple sclerosis, intention tremor, scanning speech, ocular disturbance, etc., were not present, but the patient had vertigo and a somewhat slow reaction of the pupils. The lesions were confined to the medulla oblongata, pons and a portion of the corpora quadrigemina. Muscular atrophy is rarely seen in multiple sclerosis, but has been reported, and usually no change has been found in the ganglion cells of the anterior horns. Probst found in his case diminution in number and shrinkage of these cells in the upper part of the cervical cord. Secondary degeneration of the direct and crossed pyramidal tract was especially noteworthy, and extended from the proximal end of the pons into the lumbar cord. It was apparently due to a sclerotic area in the pons. Secondary degeneration has only been observed in a few cases of disseminated sclerosis. The columns of Goll were sclerotic from the upper thoracic region to the nuclei of these columns, and the intensity of the process was greatest in the upper part of the cord. The bulbar symptoms were explicable on account of the affection of the bulbar nuclei and nerves. Probst does not believe that this case was a combination of disseminated sclerosis and amyotrophic lateral sclerosis, because the vertigo was the first sign of the disease, because the muscular atrophy did not progress as rapidly as it usually does in amyotrophic lateral sclerosis, because the degeneration of the cells of the anterior horns was not as great as is usually seen in this affection, and because the secondary degeneration of the pyramidal tracts began in a sclerotic focus.

From a study of fifty-eight clinical cases of disseminated sclerosis, Probst finds that the sexes are about equally affected, that the disease is most common between twenty and thirty years of age, that exposure to cold and wet is the most common cause, and that infectious processes come next in etiological importance.

SPILLER.

260. EIN FALL VON ISOLIERTER FACIALIS-UND HYPOGLOSSUS-LAEHMUNG NEBST PSYCHISCHER ALTERATION INFOLGE VON TYPHUS ABDOMINALIS **(A Case of Isolated Paralysis of the Facial and Hypoglossal Nerves with Psychical Alteration in Consequence of Typhoid Fever). A. Friedländer (Monatsschrift für Psychiatrie und Neurologie, 4, 1898, p. 110).**

A boy, not hereditarily afflicted but not of normal psychical development, presented no unusual symptoms until he became fourteen or fifteen years old. He had been obedient until this time, but now became disobedient and excited, spoke much, ran from the house without any known motive, etc.; later he became more quiet and was able to work. He had a severe attack of typhoid fever, and during the convalescence he manifested symptoms of acute dementia and had paralysis of the right facial nerve. His behavior was that of a little child. He exhibited mind blindness, forced laughter and periodic attacks of intense anger, and made bad poetry; in short, he presented the symptom-complex of dementia præcox. The paralysis of the right facial nerve and, to some extent of the right hypoglossal, was not believed to be peripheral, as the electrical reactions were normal; or cortical, as sensation was not affected. It was thought to be the result of a small area of softening or of a hemorrhage in the white matter close to the surface of the lower portion of the anterior central gyrus. SPILLER.

261. CASUISTISCHE MITTEILUNGEN AUS DEM GEBIETE DER MUSKELPATHOLOGIE (Clinical Communications Concerningthe Pathology of the Muscles). R. Cassirer (Monatsschrift für Psychiatrie und Neurologie, 3, 1897, p. 491, and 4, 1898, p. 21).

Cassirer reports the clinical histories of several cases illustrating the difficulties of diagnosis in diseases causing muscular atrophy. The first case was in a young girl. The disease began with severe pain in the lower limbs and the patient became quite weak in these parts. Improvement was soon noted. About a year later the child had diphtheria and scarlatina with œdema. The weakness of the lower extremities increased and the motility of the arms diminished. No pain was experienced. After two years, during which time the improvement was gradual, the small foot muscles of the plantar surface, the quadriceps femoris, the ilio-psoas, and the adductors of the thigh, the deltoid, supraspinatus, infraspinatus, and triceps muscles were especially involved, while the remaining muscles of the thigh, pelvis, abdomen and back were little affected. The paralysis was not a degenerative one and pseudo-hypertrophy was not seen. The tendon reflexes corresponded in intensity to the degree of muscular atrophy. No objective or subjective disturbance of sensation was present.

The cause of this affection could not be neuritis or spinal lesion, chiefly on account of the absence of sensory changes during a long period, and the absence of a degenerative paralysis. The very slight fibrillary twitchings, the youthful age of the patient and the irregular and extensive atrophy, were not regarded as favoring the diagnosis of spinal muscular atrophy.

The variations in the symptoms and the atrophy of the shoulder muscles, with integrity of the muscles of the hand and forearm, were against the diagnosis of progressive neurotic muscular atrophy, while the acute onset of the process with pain, the many variations in the symptoms and the distribution of the muscular atrophy were not characteristics of progressive muscular dystrophy. The case was regarded as one of primary myopathy, resulting from polymyositis, and as not conforming to any of the known types of muscular atrophy.

Two cases of progressive neurotic muscular atrophy are described which closely resembled clinically the case just mentioned, but in these, qualitative electrical changes were noted. Although cases of muscular dystrophy with reaction of degeneration have been reported, they are very exceptional, and if such reaction occurs the diagnosis of muscular dystrophy can only be made when the muscular atrophy in its distribution is characteristic of this disease. Degenerative reaction Cassirer regarded as sufficient to exclude the possibility of progressive muscular dystrophy.

A case of acute anterior poliomyelitis is reported, in which later the signs of progressive muscular dystrophy were noted. No similar combination of the two diseases seems to have been recorded in literature. Cassirer says a connection may have existed between the two diseases, but that proof was not offered. SPILLER.

262. THE NEURASTHENIC SYMPTOMS OF GASTRO-INTESTINAL DISEASE. G. W. McCasky, M. D. (Med. Record, 54, 1898, p. 371).

There is one type of gastric disease in which for some reason the local sensory symptoms of the stomach disorder are almost entirely